COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CENTRAL BUSINESS OFFICE -SYSTEMS ACCESS UNIT

INDIVIDUALS AUTHORIZED TO SIGN APPLICATION ACCESS FORMS

☐ **New** ☐ **Replace Signature(s) on File** ☐ **Add to Signature(s) on File**

Legal Entity # _____ Provider No. or Reporting Unit(s):_____

Check Provider Type: ☐ DMH ☐ NGA ☐ FFS ☐ DHS

Provider/Agency Name: _____

Address: _____
Street City State Zip

Telephone Number:___ _____
Area Code Number Extension

Director/CEO _____
Print or Type Name

Title: _____

Signature: _____

E-Mail Address: _____

The following individuals are authorized to sign Application Access Forms submitted by the above named agency:

Name of Designee: _____
Print/Type

Signature of Designee: _____

Title: _____ Phone: _____

E-Mail Address: _____

Name of Alternate: _____
Print/Type

Signature of Alternate: _____

Title: _____ Phone: _____

E-Mail Address: _____

Date Submitted to SAU: _____

PLEASE NOTE: ORIGINAL SIGNATURES ARE REQUIRED—NO FAX COPIES.

Return form to: LA County--Department of Mental Health
Provider Support Office/Systems Access Unit
695 S. Vermont Avenue, Los Angeles, CA 90005